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Community Support – Children/Adolescents (MH/SA)
Medicaid Billable Service

Service Definition and Required Components

Community Support services are those services and supports necessary to assist youth 3 to 17 years of age (20 years old or younger for children enrolled in Medicaid) and their caregivers in achieving mental health and substance abuse rehabilitative and recovery goals. This medically necessary service directly addresses the recipient's diagnostic and clinical needs. These diagnostic and clinical needs are evidenced by the presence of a diagnosable mental, behavioral and emotional disturbance (as defined by DSM-IVTR and its successors), with documentation of symptoms and effects reflected in the Person Centered Plan.

Community Support services, which are psychoeducational and supportive in nature, are intended to meet the mental health or substance abuse needs of children and adolescents who have significant functional impairment that seriously interferes with or impedes his/her role or functioning in family, school, or community activities. The service is designed to:

- increase skills to address the complex mental health and/or substance abuse needs of children and adolescents who have significant functional deficits in order to promote symptom reduction and improve age appropriate functioning in his/her daily environment, and
- assist the child/youth and family in gaining access to and coordinating necessary services to promote clinical stability and support the emotional and functional growth and development of the child.

The rehabilitative service activities of Community Support consist of a variety of interventions that must directly relate to the recipient's diagnostic and clinical needs as reflected in a comprehensive clinical assessment and outlined in the Person Centered Plan. These shall include as clinically indicated:

- one-on-one interventions with the recipient, unless a group intervention is deemed more efficacious, to develop interpersonal and community relational skills, including adaptation to home, school, work and other natural environments
- therapeutic mentoring that directly increases the acquisition of skills needed to accomplish the goals of the Person Centered Plan
- symptom monitoring
- self-management of symptoms
- medication monitoring with documented communication to prescribing physician(s)
- direct preventive and therapeutic interventions that will assist with skill building
- assistance with skill enhancement or acquisition
- relapse prevention and disease management strategies
- psychoeducation and training of family, unpaid caregivers and others who have a legitimate role in addressing the needs identified in the Person-Centered Plan (PCP)
- support for ongoing treatment and encouraging the achievement of functional gains
- care management for the effective coordination of clinical service, natural and community supports for the child/youth and his/her family

The service includes providing "first responder" **crisis response** on a 24/7/365 basis to recipients experiencing a crisis.

In partnership with the family and/or the legally responsible person, the Qualified Professional is responsible for convening the Child and Family Team. The Child and Family Team is the vehicle for the Person-Centered Planning process. The Qualified Professional consults with identified medical and non-

medical providers and engages community and natural supports and includes their input in the person centered planning process. The Qualified Professional is responsible for monitoring and documenting the status of the recipient's progress and the effectiveness of the strategies and interventions with the Child and Family Team as outlined in the Person Centered Plan.

The Community Support Qualified Professional provides and oversees case management to arrange, link, monitor, and/or integrate multiple services as well as assessment and reassessment of the recipient's need for services. The Community Support Qualified Professional provides coordination of movement across levels of care, both by interacting directly with the person and their family and by coordinating discharge planning and community re-entry following hospitalization, residential services, and other levels of care.-

Community Support staff also inform the recipient about benefits, community resources, and services; and assists the recipient in accessing benefits and services; arrange for the recipient to receive benefits and services; and monitor the provision of services. The provider organization assumes the roles of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient.

For Medicaid funded services, a personally signed service order for Community Support services must be completed by a physician, licensed psychologist, physician's assistant, or nurse practitioner, according to their scope of practice along with other documentation requirements outlined in this policy. The service order must be based on an individualized assessment of the recipient's needs. For State funded services, it is recommended that a service order is completed within the first visit.

Provider Requirements
Community Support services must be delivered by practitioners who are employed by a mental health or substance abuse provider organization that meets the provider qualification policies, procedures, and standards established by the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the Local Management Entity (LME). Within three years of enrollment as a provider, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The provider organization must be established as a legally constituted entity capable of meeting all of the requirements of Provider Endorsement, Medicaid Enrollment Agreement, Medicaid Bulletins and service implementation standards. This includes national accreditation within the prescribed timeframe.

The Community Support provider organization is identified in the Person Centered Plan. For Medicaid services, the organization is responsible for obtaining authorization from the Medicaid-approved vendor for medically necessary services identified in the Person Centered Plan. For State funded services, the organization is responsible for obtaining authorization from the Local Management Entity. The Community Support provider organization must comply with all applicable federal, state, and DHHS requirements. This includes but not limited to DHHS Statutes, Rule, Policy, Implementation Updates, Medicaid Bulletins, and other published instruction.

Staffing Requirements
Persons who meet the requirements specified (10A NCAC 27G.0104) for Qualified Professional (QP), Associate Professional (AP), and Paraprofessional status and who have the knowledge, skills, and abilities required by the population and age to be served may deliver Community Support. Qualified

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Professionals shall develop and coordinate the Person Centered Plan. Associate Professionals and Paraprofessionals will deliver Community Support services to directly address the recipient's diagnostic and clinical needs under the direction of the Qualified Professional.

All Associate Professionals and Paraprofessionals providing Community Support must be supervised by a Qualified Professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.

A Certified Clinical Supervisor (CCS) or Licensed Clinical Addiction Specialist (LCAS) may also deliver and supervise Community Support as a Qualified Professional.

The following chart sets forth the activities that can be performed by a Qualified Professional, Certified Clinical Supervisor, Licensed Clinical Addiction Specialist, Associate Professional, or Paraprofessional. These activities reflect the appropriate scope of practice for these individuals.

Qualified Professional **Certified Clinical Supervisor** **Certified Clinical Addiction Specialist**	**Associate Professional** **Paraprofessional** **(under the supervision of the Qualified Professional)**
• Coordination and oversight of initial and ongoing assessment activities • Ensure linkage to the most clinically appropriate and effective service • Convening the Child and Family Team for Person-Centered Planning • Initial development and ongoing revision of Person Centered Plan • Monitoring the implementation of Person Centered Plan • Supportive counseling to address the diagnostic and clinical needs of the recipient • Case management functions to arrange, link, monitor, and/or integrate multiple services and referrals • Coordination with the recipient's medical home (i.e., primary care physician) • Supervision of activities provided by Associate and Paraprofessional staff providing Community Support • Provision of all activities, functions, and interventions of the Community Support service definition	• Assisting with therapeutic interventions to rehabilitate: o Functional skills o Daily and community living skills o Adaptation, socialization, relational, and coping skills o Behavior and anger management skills o Self-management of symptoms • Therapeutic mentoring that directly increases the acquisition of skills needed to accomplish the goals of the Person Centered Plan • Psychoeducation and training of family, unpaid caregivers and others who have a legitimate role in addressing the needs identified in the Person-Centered Plan • Direct preventive and therapeutic interventions that will assist with skill building • Relapse prevention and disease management strategies • Ongoing symptom monitoring and management • Ongoing medication monitoring with report to medical providers • Service coordination activities within the established Person Centered Plan • Input into the Person Centered Plan modifications

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All staff must complete a minimum of 20 hours of training specific to the required components of the Community Support service definition, including crisis response, within the first 90 days of employment.

Family members or legally responsible persons of the recipient may not provide these services for reimbursement.

Service Type/Setting
Community Support is a direct and indirect periodic service in which the Community Support staff member provides direct clinical intervention and also arranges, coordinates, and monitors services on behalf of the recipient. Community Support services may be provided to an individual or a group of individuals.

Community Support providers must have the ability to deliver services in various environments, such as homes, schools, detention centers and jails (state funds only)*, homeless shelters, street locations, and other community settings.

Community Support also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his or her rehabilitation goals. Community Support includes activities and meetings for the planning, development, and revision of the recipient's Person Centered Plan.

When children are inpatients in an Institution for Mental Diseases (IMD), the Qualified Professional may provide 8 units per month of the case management component of this service in order to facilitate transition to community services. This component may not be duplicative of hospital discharge planning.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions (detention centers, youth correctional facilities, jails).

Program Requirements
Caseload size for a Community Support Qualified Professional may not exceed 1 Qualified Professional to 15 recipients. (Note: in computing caseload ratios, recipients receiving less than 4 hours of service per week may be counted as 1/2 of a recipient). Community Support services may be provided to groups of individuals, but groups may not number more than eight individuals.

The Qualified Professional shall provide a minimum of 25% of the total Community Support services provided per recipient during each authorization period. However, during the first authorized 40 units (10 hours) of Community Support service, the Qualified Professional shall provide a minimum of 50% of the units (5 hours) delivered: 1) to ensure prompt development and coordination of the required Person Centered Plan or 2) to ensure medically appropriate clinical interventions are provided based on implementation/revision of the required Person Centered Plan.

Program services are primarily delivered face-to-face with the recipient and in locations outside the agency's facility. Annually, the aggregate services that have been delivered by the agency will be assessed and documented by each provider agency using the following quality assurance benchmarks:

- All youth receiving Community Support must receive a minimum of two contacts per month, with one contact occurring face-to-face with the recipient;

- a minimum of 60% of Community Support services that are delivered must be performed face-to-face with recipients; and
- a minimum of 60% of staff time must be spent working outside of the agency's facility, with or on behalf of recipients.

Entrance Criteria

The recipient is eligible for this service when

A. significant impairment is documented in at least two of the life domains related to the recipient's diagnosis which impedes the use of the skills necessary for developmentally appropriate functioning in the community. These life domains are as follows: emotional, social, safety, medical/health, educational/vocational and legal.

AND

B. there is an Axis I or II MH/SA diagnosis (as defined by the DSM-IVTR or its successors), other than a sole diagnosis of Developmental Disability

AND

C. North Carolina Modified American Society for Addiction Medicine (ASAM) criteria are met for recipients with a substance abuse diagnosis

AND

D. the recipient is experiencing difficulties in at least **two** of the following areas as evidenced by documentation of symptoms:
   1. there has been a or there is an imminent risk for institutionalization, hospitalization, or placement outside the child's/youth's natural living environment
   2. is receiving or needs crisis intervention services or intensive in-home services
   3. has unmet identified needs related to MH/SA diagnosis as reported from multiple agencies, needs advocacy, and service coordination as defined by the Child and Family Team
   4. is abused or neglected as substantiated or found in need of services by DSS, or meets dependency as defined by DSS criteria (GS 7B101)
   5. exhibits intense verbal aggression as well as limited physical aggression to self or others, due to symptoms associated with diagnosis, which is sufficient to create functional problems in the home, community, school, job, etc.
   6. is in active recovery from substance abuse or dependency and is in need of continuing relapse prevention support

AND

E. there is no evidence to support that alternate interventions would be equally or more effective based on generally accepted North Carolina community practice standards (e.g., Best Practice Guidelines per the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Society of Addiction Medicine).

Entrance Process

Medicaid covers up to 8 unmanaged Qualified Professional hours to collect information, convene the Child and Family Team in partnership with the family, and develop the required Person Centered Plan. These unmanaged visits are only for recipients new to the service system and not to the provider. If the recipient has been receiving a Medicaid funded MH/SA service previously, prior authorization is required from point of entry. For State funded Community Support services, prior authorization is required by the Local Management Entity. When authorization is approved, the Qualified Professional will collect

information, convene the Child and Family Team in partnership with the family, and develop the required Person Centered Plan.

Relevant diagnostic information must be obtained to complete the Person Centered Plan. This requirement may be fulfilled through the completion of any comprehensive clinical assessment service. If a substantially equivalent assessment is available that reflects the current level of functioning and contains all the required elements as outlined in community practice standards as well as in all applicable federal, state, and DHHS requirements, it can be utilized as a part of the current comprehensive clinical assessment.

For Medicaid, in order to facilitate a request for the initial authorization, the required Person Centered Plan with signatures and the required authorization request form must be submitted to the Medicaid-approved vendor.

For State funded Community Support, in order to facilitate a request for the initial authorization, an required Person Centered Plan with signatures, the required authorization request form and the Consumer Admission Form must be submitted to the Local Management Entity.

During the 8 unmanaged hours or at any point while receiving Community Support, the Qualified Professional shall link the recipient to an alternative service if an equally or more effective service is clinically indicated and functionally appropriate to the needs of the child. The activities that led to the referral must be documented in the full daily service note.

Continued Stay Criteria
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan; or the recipient continues to be at risk for relapse based on current clinical assessment, history, and the tenuous nature of the functional gains;-
AND
One of the following applies:

A. Recipient has achieved current Person Centered Plan goals and additional goals are indicated as evidenced by documented symptoms.
B. Recipient is making satisfactory progress toward meeting goals and documentation that continuation of this service will be effective in addressing the goals outlined in the Person Centered Plan.
C. Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
D. Recipient fails to make progress and/or demonstrates regression in meeting goals through the strategies outlined in the Person Centered Plan. The recipient's diagnosis should be reassessed to identify any unrecognized co-occurring disorders with treatment recommendations revised based on findings.

Discharge Criteria
Any one of the following applies:

A. Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down.

B. Recipient has achieved goals and is no longer in need of Community Support services.
C. Recipient is not making progress or is regressing and all reasonable clinical strategies and interventions have been exhausted, indicating a need for more intensive services.
D. Recipient or family/legally responsible guardian no longer wishes to receive Community Support services.
E. Recipient, based on presentation and failure to show improvement despite modifications in the Person Centered Plan, requires a more appropriate best practice treatment modality based on North Carolina community practice standards (e.g., the American Academy of Child and Adolescent Psychiatry and the American Psychiatric Association Practice Guidelines).

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights in accordance with the Department's recipient notices procedure.

Expected Clinical Outcomes
The expected clinical outcomes for this service are specific to recommendations resulting from clinical assessments and meeting the identified goals in the recipient's Person Centered Plan.

Expected clinical outcomes may include:
- Symptom reduction
- Maintain recovery
- Improve and sustain developmentally appropriate functioning in specified life domains-
- Increase coping skills and social skills that mediate life stresses resulting from the recipient's diagnostic and clinical needs
- Minimize the negative effects of psychiatric symptoms and/or substance dependence that interfere with the recipient's daily living
- Uses natural and social supports
- Utilize functional skills to live independently
- Develop strategies and supportive interventions for stable living arrangement (avoidance of out-of-home placement)

Documentation Requirements
The minimum standard is a daily full service note written and signed by the person who provided the service that includes:
- the recipient's name
- Medicaid identification number
- the service provided (e.g., Community Support – Individual or Group)
- date of service
- place of service
- type of contact (face-to-face, phone call, collateral)
- purpose of the contact-
- a description of the provider's interventions-
- the amount of time spent performing the interventions
- a description of the effectiveness of the interventions

- the signature and credentials of the staff member(s) providing the service (for Paraprofessionals, position is required in lieu of credentials with staff signature).

Refer to DMA Clinical Policies and DMH/DD/SAS Records Management and Documentation Manual for more details regarding documentation requirements.

Utilization Management

Services are based upon a finding of medical necessity, must be directly related to the recipient's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals specified in the individual's Person Centered Plan. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants or the Local Management Entity for State funded services.

If the needed medical information is not yet completed when the initial prior authorization request is submitted, the appointment date(s) and historical clinical information should be included. Interim prior authorizations with variable timelines for resubmission will be given to ensure the delivery of needed services.

Typically, the medically necessary service must be generally recognized as an accepted method of medical practice or treatment. Each case is reviewed individually to determine if the requested service meets the criteria outlined under EPSDT.

Medically necessary service is authorized in the most economic mode, as long as the treatment that is made available is similarly efficacious to services requested by the recipient's physician, therapist, or other licensed practitioner.

For Medicaid, authorization by the Medicaid-approved vendor is required.

For State funded Community Support services, authorization is required by the Local Management Entity prior to the first visit. The Medicaid-approved vendor or the Local Management Entity will evaluate the request to determine if medical necessity supports more or less intensive services.

Units are billed in 15 minute increments and must include the modifier to denote level of staff providing the service.

Medicaid covers up to 780 units up to a 90-day period, based on the medical necessity documented in the required Person Centered Plan, an ITR, and supporting documentation. Community Support Services are not intended to remain at this level of intensity long term. If the initial benefit of 780 units is expended before the end of the 90-day period, a required Person Centered Plan and a new ITR must be submitted to the Medicaid-approved vendor to request additional units and/or equally or more effective clinically and developmentally appropriate alternate services.

For State funded services, the Local Management Entity will determine the initial authorization period. The required Person Centered Plan, an ITR, and supporting documentation reflecting the appropriate level of care and service must be submitted to the Local Management Entity.

Additional units may be authorized on a time-limited basis to allow time for the Qualified Professional to coordinate for alternative services.

If continued Community Support services are needed at the end of the initial authorization period, a requierd Person Centered Plan and a new ITR reflecting the appropriate level of care and service must be submitted to the approved vendor for Medicaid services or the Local Management Entity for State funded services. This should occur prior to the expiration of the authorization.

No additional Community Support services can be requested without a required Person Centered Plan with signatures and an ITR.

Service Exclusions/Limitations

An individual can receive Community Support services from only one Community Support provider organization at a time.

For the purpose of facilitating an admission to a service and making a transition to or from a service; insuring that the service provider works directly with the Community Support Qualified Professional and/or discharge planning, Community Support-Individual services can be billed for a maximum of 8 units per 30 day period for individuals who are authorized to receive one of the following services during the same authorization period:

- Child and adolescent day treatment
- Intensive in-home services
- Multisystemic Therapy
- Partial hospitalization
- Substance abuse intensive outpatient treatment
- Levels II through IV child residential treatment
- Substance abuse residential services
- PRTF
- Inpatient services

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.